DISTRICT OF COLUMBIA
DOH Office of Adjudication and Hearings
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DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH Petitioner, v. D.C. FAMILY SERVICES and SHEILA A. GAITHER Respondents	Case No.: I-00-40138

FINAL ORDER

I. Introduction

On June 1, 2000, the Government served a Notice of Infraction (No. 00-40138) upon Respondents D.C. Family Services, Inc. and Sheila Gaither alleging that they violated 22 DCMR 3520.3, which describes certain professional services that an operator of a group home for mentally retarded persons must provide to the residents, and 22 DCMR 3510.5(d), which requires a group home to provide training to its staff in emergency procedures. The Notice of Infraction alleged that the violations had occurred or been determined on May 9, 2000 at 114 Division Avenue, N.E. It sought a fine of $500 for the alleged violation of § 3520.3 and a fine of $100 for the alleged violation of § 3510.5(d).

Respondents filed a timely plea of Deny, and I issued an order consolidating this case with Case No. I-00-40084, which involves the same Respondents. The order set a hearing date of July 21, 2000 in both cases. All parties appeared on that date. Carmen Johnson, Esq.

represented the Government and Kathleen Deenihan, the Director of Health Services for D.C. Family Services, appeared on behalf of Respondents. Due to the length of the hearing, I heard evidence only on the allegations involving Case No. I-00-40138 on July 21. I held a separate hearing on the allegations in Case No. I-00-40084 on August 25, 2000.

On August 29, 2000, I issued an order reopening the record and requiring Respondents to file copies of the Individual Habilitation Plans for the residents at issue in both cases. Respondent filed both plans, and I permitted the parties to file additional evidence or written arguments related to those plans by September 18, 2000. The record closed on that date without the parties' filing any additional materials. Although I consolidated the cases before the hearing, the evidence has now made it clear that there is no factual overlap between them. Accordingly, I will decide them in separate orders.

Based upon the testimony of all the witnesses, my evaluation of their credibility, the documents introduced into evidence and the entire record in this matter, I now make the following findings of fact and conclusions of law.

II. Findings of Fact

A. Background

Respondent D.C. Family Services, Inc. ("DCFS") operates a group home for mentally retarded persons located at 114 Division Avenue, N.E.[1] Respondent Sheila Gaither is the Chief Executive Officer of DCFS. At issue in this case is the medical care provided to one of the residents of the facility, who will be identified as Client # 1.

[1] DCFS is a private entity and is unaffiliated with the District of Columbia Government.

At the time of the incidents in question, Client # 1 was 84 years old. He was classified as moderately to severely mentally retarded, and he suffered from a number of other chronic conditions, including cerebral palsy, seizure disorder, and hypertension. He also had a history of strokes and he underwent a permanent colostomy in 1990, due to colon cancer. Client # 1 came to the Division Avenue Facility in 1995, after spending more than 60 years in various institutional settings.

Client # 1 died on May 1, 2000. Early that morning, staff members at the group home found that he was non-responsive and was having difficulty breathing. He was taken by ambulance to the emergency room, where he was pronounced dead shortly after his arrival there. After investigating the circumstances of his death, the Government issued the Notice of Infraction, believing that DCFS failed to provide appropriate medical care for him and that some facility employees were not properly trained in first aid procedures.

B. The Medical Care Issues

DCFS prepared an individual habilitation plan ("IHP") for Client # 1 in October 1999. The medical recommendations incorporated into that plan included the following: "Maintain optimal health to include annual physical exam, labs as needed, monitor seizure precautions, maintain colostomy and skin care." IHP at 14. To prevent dehydration, the IHP also called for the staff to "[e]ncourage [Client # 1] to drink 8-10 glasses of water." *Id.*[2]

Client # 1 had been hospitalized and seen in an emergency room for seizures and dehydration on several occasions in the months before his death. As a precaution against the

[2] Presumably, this provision referred to a daily intake of water, although the IHP does not say so explicitly.

onset of another seizure, the group home's nursing staff checked his pulse every day, and had done so for at least six months before he died. Until approximately ten days before his death, Client # 1's pulse rate had varied between 62 and 82. There was no evidence that this was a cause for concern. In the ten days before his death, however, the rate increased, fluctuating between 94 and 108. Ms. Deenihan, who is a registered nurse, admitted that the increase warranted an evaluation by a physician. DCFS, however, did not arrange for a visit to a physician during this period.

The Government also presented evidence that Client # 1's hemoglobin and potassium levels were slightly below normal on some occasions during the year before his death. The Government did not, however, present any evidence of what the appropriate medical response, if any, should have been to those levels.

The Government also argued that Respondents did not follow the medical plan described in Petitioner's Exhibit ("PX") 6, a letter from Ms. Deenihan to the Department of Health's Medical Assistance Administration ("MAA") dated November 29, 1999. PX 6 is DCFS's response to an inquiry from MAA concerning Client # 1 after he had been taken to the emergency room in August 1999 complaining of chest pain and shortness of breath. DCFS responded as follows:

> DCFS' medical plan for [Client # 1] remains the same as previously. That is:
>
> * monitor sensorium at least every ½ hour
> * daily B/P [blood pressure] monitoring
> * vital signs weekly and as warranted
> * monitor pedal edema daily
> * monitor respiratory status daily

PX 6.

The Government contends that PX 6 represented an ongoing medical plan for Client # 1 and that DCFS had not been implementing it in the days before Client # 1's death. Respondents contend that PX 6 was only a temporary plan established in response to the specific incidents that led to the August 1999 emergency room visit, and that it was no longer in effect by April 2000. Because PX 6 was not incorporated into Client # 1's IHP, I need not resolve this factual dispute. See pp. 7-9 *infra.*

The parties also dispute what plans DCFS had adopted to prevent Client # 1's dehydration. The Government's witnesses testified that DCFS had instructed the staff to give him a glass of water every hour, although it introduced no documentation of such a plan. Respondents' witnesses insisted that there was no such plan. The only documentary evidence of DCFS's plans to prevent dehydration is the IHP, which requires the group home staff to encourage Client # 1 to drink 8 to 10 glasses of water. The Government introduced no evidence showing that Respondents failed to implement that plan. Because the IHP does not require a glass of water per hour, I also do not need to decide whether Respondents ever adopted such a plan.

C. The First Aid Issues

Client # 1 was taken to the hospital at approximately 5:30 AM on May 1, 2000. Two overnight staff members were on duty at that time. They had attended various in-service training courses in first aid and emergency procedures offered by DCFS. Both staff members told the Government's investigator that they did not know how to check a resident's vital signs (*i.e.,* temperature, pulse, respiration and blood pressure). It is DCFS's practice to have a member of the nursing staff, not one of the direct care workers, check a resident's temperature and blood

pressure when required. The staff members also told the investigator that they did not know how to recognize seizures. Ms. Shade, a registered nurse employed by the Department of Health, testified that, in her opinion, the staff members' training in first aid should have included training in how to take vital signs and how to recognize seizures.

III. Conclusions of Law

A. Liability of Ms. Gaither

The Notice of Infraction names both Ms. Gaither and DCFS as Respondents. The only evidence concerning Ms. Gaither, however, is that she is an officer of DCFS. There was no evidence that she had any involvement in any of the incidents at issue or that she was responsible in any way for first aid training. While a company is liable for civil infractions committed by its employees, 16 DCMR 3201.4, there is no authority for holding that a company's officers, simply by virtue of their position, are generally liable for violations committed by the company's employees.[3] Nor has the Government pointed to any specific regulation that imposes liability upon the Chief Executive Officer of a group home operator for all violations that occur at a home. Consequently, there must be evidence of Ms. Gaither's actual involvement in the violations charged in order to hold her liable. Because there is no such evidence in this record, the charges against her must be dismissed. *Compare DOH v. Linde,* OAH No. I-00-10004 at 5-6 (Final Order, August 6, 2001) (shareholder liable because evidence demonstrated his personal involvement in the violations). *See also Browning-Ferris Industries v. Ter Maat,* 195 F.3d 953,

[3] To be sure, some regulations (not at issue in this case) impose liability upon specific individuals when certain violations occur. *See, e.g.,* 22 DCMR 3523.1 (group home's residence director must ensure that residents' rights are protected); *DOH V. Ferguson,* OAH No. I-00-40305 at 3-5 (Final Order, August 31, 2001) (29 DCMR 320.3 holds the caregiver in a child development home liable for regulatory violations occurring there).

955-56 (7th Cir. 1999) (corporate officers who are not personally involved in the corporation's unlawful acts are not liable for those acts).

B, Section 3520.3

The Notice of Infraction alleges a violation of 21 DCMR 3520.3, which provides:

> Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.

As noted in the August 29, 2000 Order Reopening the Record in this matter, § 3520.3 "does not establish a standard of conduct that a Respondent can 'violate.' " August 29, 2000 Order at 2. Instead,

> [t]he relevant standard of conduct is found in 22 DCMR 3520.1, which requires that every resident of a group home for mentally retarded persons "shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan . . . ." In order to establish a violation of that section, therefore, the Government must prove that a group home operator failed to furnish professional services to meet the needs identified in a resident's individual habilitation plan. Section 3520.3, in turn, identifies specific professional services that a group home operator must furnish to comply with §3520.1. Thus, the charge that Respondents "violated" §3520.3 is actually an allegation that they failed to meet their obligations under 3520.1 because they did not provide professional services described in §3520.3 that are necessary to meet Client # 1's needs as identified in his individual habilitation plan.

DOH v. Community Multi-Services, Inc., OAH No. I-00-40136, at 12-13 (Final Order, August 29, 2000).

Thus, the Government can prove its case only by showing that DCFS did not provide a professional service for Client # 1 that was necessary to meet his needs as specified in his IHP.

Merely showing that some necessary or desirable medical service was not provided does not violate §§ 3520.1 and 3520.3. *Community Multi-Services, supra,* at 13.[4]

Client # 1's IHP called for the facility's nurse or primary care physician to "monitor seizure precautions," and the daily taking of his pulse was one of those precautions. The facility complied with the letter of the plan, as it monitored his pulse every day. The question presented is whether that literal compliance was sufficient in light of the undisputed evidence that further action should have been taken when the monitoring revealed the increase in his pulse rate over the ten-day period before he died. The IHP itself makes clear that the monitoring of seizure precautions is not an end in itself, but is a means to "[m]aintain optimal health" for Client # 1. IHP at 14. This means that appropriate medical action should be taken if the monitoring reveals the need for such action. No one disputes that further medical intervention, including evaluation by a physician, was necessary in light of the increased pulse. DCFS's failure to arrange for that intervention, therefore, was a failure to provide professional services called for in Client # 1's IHP. That failure violates §§ 3520.1 and 3520.3. A fine of $500 is authorized for that violation. 16 DCMR 3239.2(e).

The evidence of the other incidents presented by the Government does not establish any violations of §§ 3520.1 and 3520.3. While the Government's witnesses identified low potassium and hemoglobin levels on certain occasions, there was no evidence that DCFS failed to take

[4] This does not mean that the Government is without a remedy if a group home fails to provide necessary medical services that are not specified in an IHP. As pointed out in an earlier order in *Community Multi-Services*: "District of Columbia law and federal law grant group home residents a general right to medical care. E.g., D.C. Code § 6-1965(g); 42 CFR 483.460(a)(3). Failure to protect that right would violate 22 DCMR 3523.1, subjecting the violator to an action by the Government for civil penalties." *DOH v. Community Multi-Services,* OAH No. I-00-40136, at 2, n.1 (Order Reopening the Record, June 29, 2000).

appropriate action in light of those levels. While the Government offered testimony that there was some plan for Client # 1 to drink a glass of water every hour of the day, no such plan was incorporated into the IHP. Even if such a plan existed, any failure to follow it could not violate §§ 3520.1 and 3520.3. Similarly, the dispute about whether PX 6 represented a current plan for Client # 1 as of April 2000 or whether it was only a temporary measure resulting from his hospitalization in August 1999 is irrelevant. PX 6 was not part of the IHP and failure to comply with it could not be a violation of §§ 3520.1 and 3520.3.[5]

C. Section 3510.5(d)

The Government also alleges that Respondents violated 22 DCMR 3510.5(d), which requires staff training programs to include instruction in "[e]mergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans." The Government faults the first aid training of the staff members on duty on the night that Client # 1 died in two respects, *i.e.*, the staff members were not trained in taking vital signs and were not trained in the recognition of seizures.

DCFS initially contends that it did not violate § 3510.5(d), because the staff members in question attended several in-house first aid training classes. Compliance with the regulation, however, can not be established merely by showing that staff members sat in a classroom for a certain number of hours. By specifying the components of a proper training program, the regulation seeks to ensure that group home workers become sufficiently knowledgeable about

[5] Although the IHP requires monitoring of "seizure precautions," the Government presented no evidence that the measures described in PX 6 were "seizure precautions."

the subjects identified. Thus, the staff members' mere attendance at classes, without more, does not guarantee compliance.[6]

The question that remains, however, is what specific information must be learned in a first aid training program and, in particular, whether there must be training in the taking of blood pressure, temperature, pulse and respiration as well as in the recognition of seizures. Section 3510.5(d) requires training in specific first aid measures like CPR and the Heimlich maneuver in addition to the general "first aid" requirement, but otherwise offers no guidance on this issue. "First aid" is not defined in the regulation, and available dictionary definitions are not sufficiently specific. *E.g.* American Heritage Dictionary of the English Language (2000) ("emergency treatment administered to an injured or sick person before professional medical care is available.")

What constitutes appropriate first aid training for group home employees is not " 'within the realm of common knowledge and everyday experience,' " at least with respect to the matters at issue here. *District of Columbia v. Hampton,* 666 A.2d 30, 36 (D.C. 1995) (quoting *Matthews v. District of Columbia,* 387 A.2d 731,735 (D.C. 1978).[7] Therefore, expert testimony was

[6] I do not decide in this case when, how and how often the adequacy of staff members' knowledge of the topics specified in §3510.5 must be measured. I have decided only to reject Respondents' argument in favor of a *per se* rule that class attendance, by itself, is a complete defense to a charge of violating §3510.5 in all circumstances. As with other regulations, the Government will continue to bear the burden of proof in any case alleging a violation of § 3510.5. D.C. Code § 1-1509(b), now codified as D.C. Code § 2-509 (2001 ed.); D.C. Code § 6-2713(a), now codified as D.C. Code § 2-1802.03(a) (2001 ed.).

[7] There may be some tasks that ordinary experience teaches are a part of first aid, *e.g.,* bandaging a minor cut. Such experience also teaches, however, that trained medical professionals usually perform tasks such as taking blood pressure readings. Whether it is appropriate for non-medical personnel to do so in the course of rendering first aid is not at all obvious. Expert testimony, therefore, is required to establish the point. With respect to recognition of seizures, the Government offered no evidence establishing either that Client # 1

required to establish that proper first aid training requires knowing how to take blood pressure, temperature, pulse and respiration, as well as knowing how to recognize seizures. *See, e.g., Hill v. Metropolitan African Methodist Episcopal Church,* 2001 D.C. App. Lexis 187 (D.C. August 30, 2001) (expert testimony required on crowd control measures); *Katkish v. District of Columbia,* 763 A.2d 703, 705-06 (D.C. 2000) (care and maintenance of trees); *District of Columbia v. Arnold & Porter*, 756 A.2d 427, 433-35 (D.C. 2000) (operation and maintenance of a municipal water system); *Phillips v. District of Columbia*, 714 A.2d 768, 773 (D.C. 1998) (care of prisoners); *Messina v. District of Columbia*, 663 A.2d 535 (D.C. 1995) (safety of playground equipment).[8]

In an effort to show the elements of appropriate first aid training, the Government presented Ms. Shade's testimony that such training should include instructions on how to take all four vital signs and on how to recognize seizures. She did not, however, offer anything beyond her own opinion on this issue. Expert testimony, however, must consist of more than "the expert's opinion as to what he or she would do under similar circumstances." *Toy v. District of Columbia,* 549 A.2d 1, 7 (D.C. 1988). *See also*, *Phillips, supra,* 714 A. 2d at 773; *Messina, supra,* 663 A.2d at 537. The expert must point to a "standard of care beyond the expert's personal opinion" in order to provide sufficient support for the Government's case. *Toy, supra,*

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suffered a seizure when the workers in question were on duty or, if he did, that they failed to give him proper first aid. Their statements that they did not know how to recognize a seizure does not necessarily mean that they did not know how to provide first aid to someone exhibiting the symptoms of a seizure. Indeed, the Government offered no evidence to show what the proper first aid for those symptoms might be.

[8] Each of the cited cases is a tort claim for negligence. The Court of Appeals' holdings are also applicable in this regulatory context because the issue is fundamentally the same, *i.e.,* how to prove a standard of care when common knowledge and experience do not provide the answer and when the legislature and regulatory authorities have not addressed the issue.

549 A.2d at 7. The Government offered no such evidence.[9] Consequently, the evidence is insufficient to hold that group home workers' first aid training must include taking of vital signs and recognition of seizures. Because the Government has not met its burden of proof on the charge of violating § 3510.5(d), that charge will be dismissed.

IV. ORDER

Based upon the foregoing findings of fact and conclusions of law, it is, this _____ day of _____, 2001:

ORDERED, that Respondent Sheila Gaither is **NOT LIABLE** for violating either 21 DCMR 3520.3 or 21 DCMR 3510.5(d) alleged in the Notice of Infraction; and it is further

ORDERED, that Respondent DC Family Services, Inc. is **LIABLE** for violating 22 DCMR 3520.3 as alleged in the Notice of Infraction; and it is further

ORDERED, that Respondent DC Family Services, Inc. is **NOT LIABLE** for violating 22 DCMR 3510.5(d) as alleged in the Notice of Infraction; and it is further

[9] In negligence cases, the Court of Appeals has insisted that expert testimony demonstrate either a nation-wide standard of care or the existence of practices that are generally followed in the relevant field. *E.g., Arnold & Porter, supra,* 756 A.2d at 433; *Phillips, supra,* 714 A.2d at 775. In this case, it is not necessary to decide whether the Government must prove such universal acceptance of a standard for first aid training in order to prove a violation of § 3510.5(d). It is enough to hold that the Government must provide evidence of some reasonably accepted standard for determining what constitutes adequate first aid training and that it did not do so.

ORDERED, that Respondent DC Family Services Inc. shall pay a total of **FIVE HUNDRED DOLLARS ($500)** in accordance with the attached instructions within twenty (20) calendar days of the date of service of this Order (15 days plus 5 days service time pursuant to D.C. Code §§ 6-2714 and 6-2715, now codified as D.C. Code §§ 2-1802.04 and 2-1802.05 (2001 ed.); and it is further

ORDERED, that if Respondent fails to pay the above amount in full within twenty (20) calendar days of the date of mailing of this Order, interest shall accrue on the unpaid amount at the rate of 1 ½% per month or portion thereof, starting from the date of this Order, pursuant to section 203(i)(1) of the Civil Infractions Act, D.C. Code § 6-2713(i)(1), as amended by the Abatement and Condemnation of Nuisance Properties Omnibus Amendment Act of 2000, D.C. Law 13-281, effective April 27, 2001, now codified as D.C. Code § 2-1802.03(i)(1) (2001 ed.) ; and it is further

ORDERED, that failure to comply with the attached payment instructions and to remit a payment within the time specified will authorize the imposition of additional sanctions, including the suspension of Respondent's licenses or permits pursuant to D.C. Code § 6-2713(f), now codified as D.C. Code § 2-1802.03(f) (2001 ed.), the placement of a lien on real and personal property owned by Respondent pursuant to D.C. Code § 6-2713(i), now codified as D.C. Code

§ 2-1802.03(i) (2001 ed.) and the sealing of Respondent's business premises or work sites pursuant to D.C. Code § 6-2703(b)(7), now codified as D.C. Code § 6-1801.03(b)(7) (2001 ed.).

/s/ 10/22/01

John P. Dean
Administrative Judge